

Exemption No. \_\_\_\_\_  
(291)

STATE OF NEW JERSEY  
DEPARTMENT OF BANKING AND INSURANCE

EMPLOYER'S APPLICATION FOR RENEWAL OF EXEMPTION FROM INSURING ALL OR PART OF  
ITS COMPENSATION LIABILITY

(As provided by **N.J.S.A 34:15-77**)

Name of employer \_\_\_\_\_

Address \_\_\_\_\_

Incorporated or organized under the laws of the State of \_\_\_\_\_ on \_\_\_\_\_

Employer's Federal Employer Identification Number (FEIN) \_\_\_\_\_

Registered under the Securities Act of 1933 (15 U.S.C. Sec. 77 et seq.) Yes ☐ No ☐

Nature of business \_\_\_\_\_

(Retail, Manufacturing, Engineering, Construction, etc)

If the employer is a subsidiary, complete the following:

Exact legal name of the *ultimate parent* \_\_\_\_\_

Date parent incorporated \_\_\_\_\_ State \_\_\_\_\_ FEIN \_\_\_\_\_

Has an application for workers' compensation insurance ever been refused or a policy canceled? Yes ☐ No ☐  
If yes, attach an explanation of circumstances including date, name of jurisdiction, and name of carrier.

Has an application for self-insurance ever been denied or a certificate revoked? Yes ☐ No ☐  
If yes, attach an explanation of circumstances including date and name of jurisdiction.

Is the employer self-insured in any other jurisdiction? Yes ☐ No ☐  
(If yes, see item 3 on page 3.)

Company contact for self-insurance: \_\_\_\_\_

Title: \_\_\_\_\_

Street address: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email \_\_\_\_\_

Third Party Claims Administrator (If applicable). Name of company: \_\_\_\_\_

Contact person and Title: \_\_\_\_\_

Street address: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email \_\_\_\_\_

Excess Insurance Carrier: \_\_\_\_\_

Policy Period: \_\_\_\_\_

Policy Limits: \_\_\_\_\_

Retention Amount: \_\_\_\_\_

Exemption No. \_\_\_\_\_  
(291)

**LOSS EXHIBIT**

A. Total amount of compensation (indemnity only) PAID during past year \$ \_\_\_\_\_

B. Total amount of medical, hospital and surgical expense for the past year  
including cost of supplies and equipment for employer's plant hospital  
(paid \$ \_\_\_\_\_) total incurred \$ \_\_\_\_\_

C. Outstanding Indemnity Reserve (total of reserve as per last column of 291A) \$ \_\_\_\_\_

D. Total incurred loss for past year [A. + B. + C. - C. (prior year)] \$ \_\_\_\_\_

\_\_\_\_\_  
(Signature of Employer)

By \_\_\_\_\_  
(Name)

Dated at \_\_\_\_\_, \_\_\_\_\_, 20\_\_\_\_

**AFFIDAVIT**

(The person subscribing to the below affidavit should be the employer himself; or if the employer is a partnership, one of the partners; or if the employer is a corporation, its president, vice president, secretary or treasurer.)

**STATE OF** \_\_\_\_\_

**County of** \_\_\_\_\_

\_\_\_\_\_ first being duly  
sworn on oath deposes and says that he is acquainted with the affairs of the above-mentioned employer, to which  
representations and statements set forth in the foregoing application relate; that he has read the application, knows  
the contents thereof and that said representations and statements therein contained are true to the best of his  
knowledge and belief.

Subscribed and sworn to me at

\_\_\_\_\_ NJ >

This \_\_\_\_\_ day of \_\_\_\_\_ >

\_\_\_\_\_, A.D. 20 \_\_\_\_\_ >

\_\_\_\_\_

\_\_\_\_\_  
(Official Title)

	ATTACHMENTS	
	<b>Attachments detailed below are required, and must be provided before the renewal application is considered complete. Failure to comply may result in your renewal being denied</b>	
1	Completed Certification Form (see attached)	
2	Provide audited financial statements (annual reports) with accompanying footnotes and auditors' opinion, and 10K's, if applicable, for the most current year.	
3	Provide a list of all other Self-Insured Jurisdictions and the amounts of security deposits on file.	
4	Provide a narrative description of the safety program components for your operations in this state.	
5	Provide Loss Runs (open claims) for the period of self insurance. (use form 291A).	
6	Completed Supplement 1 (see attached)	

Exemption No. \_\_\_\_\_  
(290)

**Supplement 1**

**Exhibit of Locations of Shops and other Workplaces, Number of Employees, Payrolls and Description of Operations in New Jersey**

This report covers the latest fiscal period of the Employer extending from \_\_\_\_\_ to \_\_\_\_\_

<i>Location of Factory, Office or other work place by town, city or other designation</i>	<i>Estimated Average Number of Employees at each Location</i>	<i>Division of Operations</i> (Payroll and number of employees are to be given on separate lines for each operation at each location)	<i>Actual Payroll Expenditure for past Year</i>
	0		\$ 0.

Total estimated average number of employees (worldwide) \_\_\_\_\_, and total payroll expenditure in the past year (worldwide) \$ \_\_\_\_\_ for *all* operations wherever conducted.

**CERTIFICATION** (11:2-33.4(a)5

The certificate holder recognizes that it may be subject to examination by the Commissioner as required pursuant to the New Jersey Administrative Code 11:2-33.4(a)5.

---

(Name of Company)

BY:

---

(Person's Name) and (Title)  
Printed or Typed

---

(Person's Signature) and (Date)